8530 Eagle Point Blvd, Suite 100, Lake Elmo, MN 55042
2718 Gateway Ave, Suite 103, Bismarck, ND 58503
3523 45th St. S Suite 100, Fargo, ND 58104
15310 Amberly Dr., Suite 250, Tampa, FL 33647
Phone: 651-333-9133 | Fax: 1-651-560-7013 | frontdesk@timewisemedical.com |

AUTHORIZATION OF RELEASE OF INFORMATION

Patient's Name: Date of Birth:

I request and authorize **TimeWise Medical** to receive / disclose healthcare information to/from:

Clinic/Organization/Individual: _____
Address: _____
Phone: _____ Fax: _____

This request and authorization request applies to:

□ General Medicine Date(s) of Service: _____
□ Pain Management Date(s) of Service: _____
□ M.A.T Program Date(s) of Service: _____

ONLY record type checked below:

□ Treatment Plan & Review □ Progress/Clinic Notes □ MN Prescription Monitoring Program □ X-rays
□ Medication Records □ Drug Screens □ MRI □ Bone Density
□ Discharge Summary □ Lab Results □ Other: _____

The above information is needed for the specific purpose(s):

□ Continuing care □ Verify prescribed medication □ Insurance payment/claim
□ Transfer of care □ Personal use or review □ Other: _____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidential of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise proved for in the regulations. I understand that TimeWise Medical will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information. Once the health information has been released to another facility/provider/individual, there is no way to cancel or stop the release. I understand that when the health information is released, the information could be re-disclosed by the third party that received it and may no longer be protected by federal or state privacy laws. I understand that I may revoke this consent at any time, verbally or in writing, except to the extent that action has been taken in reliance on it and that any event that consent expires one year of my signature unless specified. Expiration Date: _____

Signature: Date:

This information has been disclosed to you from records protected by Federal Confidentiality rule (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict the use of information to criminally investigate or prosecute any alcohol or drug abuse patient. If you have received this message/fax in error, please shred all documents. Any duplication of items is prohibited. Contact TimeWise Medical at 651-333-9133 immediately.